

Synagis®

for RSV Season November 28, 2011 through May 14, 2012

REQUEST BY PRESCRIBER ONLY**Fax this request to: (888) 603-7696****Questions?** Call Magellan Medicaid Administration at (800) 331-4475**Or mail this request to:** Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

REQUESTOR	Must be requested by prescriber. See below.			
RECIPIENT	Last, First Name, Middle I.:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
DOB: <small>mm/dd/yyyy</small>	Medicaid ID: <small>(10-digits)</small>		Phone #	Fax #
PRESCRIBER	Name:	NPI:		
PHARMACY	Name:	NPI:		
REQUEST	Synagis 50mg NDC 60574411401 1 dose per month		Requested Start Date:	
	Synagis 100mg NDC 60574411301 1 dose per month		Requested Start Date:	

***** All sections must be completed or the request will not be approved*******RATIONALE FOR PRIOR AUTHORIZATION**<http://hss.state.ak.us/dhcs/pharmacy/medpriorauthoriz.htm>**Gestational Age:** _____ Weeks _____ Days *Note: Weeks and days are both required* **Weight in kilograms** _____

Diagnosis of Chronic Lung Disease (formerly called bronchopulmonary dysplasia) **AND** child must be ≤ 24 months of age at onset of season on Nov. 28 (DOB after 11/28/09) **AND** child has required medical treatment in the preceding 6 months.

Check/Complete all that apply:

- Oxygen most recent date administered: _____
 Corticosteroids most recent date administered: _____
 Bronchodilators most recent date administered: _____
 Other - most recent date administered: _____

The infant may be approved for no more than 6 monthly doses of palivizumab.

Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease (CHD) **AND** child must be ≤ 24 months of age at onset of season on November 28 (DOB on or after 11/28/09).

*The infant may be approved for no more than 6 monthly doses of palivizumab.**If the child undergoes cardio-pulmonary bypass surgery during the RSV season, an extra post-operative dose may be authorized.* Cardio-pulmonary bypass surgery; Date: _____

Child is < 12 months of age on November 28 (DOB after 11/28/10) **AND**

 Gestational age ≤ 28 weeks, 6 days,**OR**

Child is < 12 months of age on November 28 (DOB after 11/28/10) **AND** diagnosed with:

 Congenital abnormalities of the airway **OR** Neuromuscular condition that compromises handling of respiratory secretions. **Diagnosis Code:** _____*The infant may be approved for no more than 6 monthly doses of palivizumab.*

Child is < 6 months of age on Nov. 28 (DOB after 5/28/11) **AND** gestational age is 29 weeks, 0 days through 31 weeks, 6 days or less.

The infant may be approved for no more than 6 monthly doses of palivizumab.

Child is < 3 months of age on Nov. 28 (DOB on 9/1/11 or after) **AND** gestational age is 32 weeks, 0 days through 34 weeks, 6 days, **AND: (check any that applies)**

 Child attends daycare, **OR** Child resides in a home with another child < 5 years of age **OR** Child resides in a crowded living environment (≥ 3 children per bedroom or ≥ 7 people per household) **OR** Child resides in a home with lack of running water*The infant may be approved for no more than 3 monthly doses or a monthly dose until the infant reaches 90 days of age, whichever comes first.***Prescriber's Signature****Date**

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